Mental Health Skill-Building Services (MHSS)

Last Updated: 10/20/2023

Service Type:
0650 Community Mental Health Rehab Services
Procedure Code:
H0046

Admission Criteria Diagnosis, Symptoms, and Functional Impairment:

Individuals qualifying for MHSS must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities.

Individuals age 21 and over shall meet all of the following criteria in order to be eligible to receive MHSS:

- The individual shall have one of the following as a primary mental health diagnosis:
  - Schizophrenia or other psychotic disorder as set out in the DSM-5,
  - Major Depressive Disorder;
  - Bipolar I or Bipolar II;
  - Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year that includes all of the following: (i) is a serious mental illness; (ii) results in severe and recurrent disability; (iii) produces functional limitations in the individual's major life activities that are documented in the individual's medical record, AND; (iv) the individual requires individualized training in order to achieve or maintain independent living in the community.

- The individual shall require individualized goal directed training in order to acquire or maintain self-regulation of basic living skills such, as symptom management; adherence to psychiatric and physical health medication treatment plans; appropriate use of social skills and personal support system; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; money management; and use of community resources.

- The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) Community Stabilization, 23- hour Crisis Stabilization or Residential Crisis Stabilization Unit Services, (iii) ICT or Program of Assertive Community Treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility as a result of decompensation related to the individual's serious mental illness; or (v) a temporary detention order (TDO) evaluation pursuant to the Code of Virginia §37.2-809(B). This criterion shall be met in order to be initially admitted to services, and not for subsequent authorizations of service. See the Documentation and Utilization Review section for additional information.

- The individual shall have had a prescription for antipsychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the Comprehensive Needs Assessment. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that anti-psychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation shall be maintained in the individual's MHSS record, and the provider shall document and describe how the individual will be able to actively

participate in and benefit from services without the assistance of medication. This criterion shall be met upon admission to services, and not for subsequent authorizations of service. See the Documentation and Utilization Review section for additional information. Individuals 18-20 years shall meet all of the above medical necessity criteria listed in paragraphs 1 through 2 (A-D) in order to be eligible to receive MHSS and the following:

- The individual shall not be in a supervised setting as described in §63.2-905.1 of the Code of Virginia. If the individual is transitioning into an independent living situation, services shall only be authorized for up to six months prior to the date of transition.

Individuals eligible for this service may have a dual diagnosis of either mental illness and developmental disability or mental illness and substance use disorder. If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within MHSS as long as the treatment for the substance use disorder is intended to positively impact the mental health condition. The impact of the substance use disorder on the mental health condition must be documented in the Comprehensive Needs Assessment, the ISP, and the progress notes.

Exclusions and Service Limitations:

In addition to the “Non-Reimbursable Activities for all Mental Health Services” section in Chapter IV, the following service limitations apply:

- TGH and assisted living facility providers shall not serve as the MHSS provider for individuals residing in the providers’ respective facility. Individuals residing in facilities may, however receive MHSS from another MHSS agency not affiliated with the owner of the facility in which they reside. “Affiliated” means any entity or property in which a group home or assisted living facility has a direct or indirect ownership interest of 5 percent or more, or any management, partnership or control of an entity.
- MHSS shall not be reimbursed for individuals who are receiving inhome residential services or congregate residential services through the Intellectual Disability (ID) or Individual and Family Developmental Disabilities Support (IFDDS) waivers.
- MHSS shall not be reimbursed for individuals who are also receiving Independent Living Skills Services, the Department of Social Services (DSS) Independent Living Program, Independent Living Services, or Independent Living Arrangement or any CSAfunded independent living skills programs.
- Medicaid coverage for MHSS shall not be available to individuals who are receiving Treatment Foster Care.
- Medicaid coverage for MHSS shall not be available to individuals who reside in intermediate care facilities for individuals with intellectual disabilities (ICF/IDs) or hospitals.
- Medicaid coverage for MHSS shall not be available to individuals who reside in nursing facilities, except for up to 60 calendar days prior to discharge. If the individual has not been discharged from the nursing facility during the 60 calendar day period of services, MHSS shall be terminated, and no further service

authorizations shall be available to the individual unless a provider can demonstrate and document that MHSS are necessary. Such documentation shall include facts demonstrating a change in the individual's circumstances and a new plan for discharge requiring up to 60 calendar days of MHSS.
- Medicaid coverage for MHSS shall not be available for residents of Psychiatric Residential Treatment Facilities, except for the assessment code H0032 (modifier U8) in the seven days immediately prior to discharge.
- MHSS shall be not reimbursed if personal care services or attendant care services are being receiving simultaneously, unless justification is provided why this is necessary in the individual's MHSS record. Medical record documentation shall fully substantiate the need for services when personal care or attendant care services are being provided. This applies to individuals who are receiving additional services through a Developmental Disabilities Waiver, CCC Plus Waiver, and EPSDT services.
- MHSS shall not be duplicative of other services. Providers have a responsibility to ensure that if an individual is receiving additional therapeutic services that there will be coordination of services by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHPC, QMHP-E or QPPMH under the supervision of a QMHP-A, QMHP-C, QMHP-E, LMHP, LMHP-S, LMHP-R or LMHP-RP to avoid duplication of services.
- Individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, will be prohibited from receiving/ will not qualify for Medicaid coverage for MHSS unless their physicians issue a signed and dated statement indicating that this service can benefit the individual by enabling them to achieve and maintain community stability and independence.
- Individuals who are not diagnosed with a serious mental disorder but who have personality disorders or other mental health disorders, or both, that may lead to chronic disability, will not be excluded from the MHSS services eligibility criteria provided that the individual has a primary mental health diagnosis from the list included in 12VAC30-50-226 and that the provider can document and describe how the individual is expected to actively participate in and benefit from MHSS and the remaining MHSS service criteria and guidelines are satisfied.
- Academic services are not reimbursable. Any services provided to the individual that are strictly academic in nature shall not qualify for Medicaid reimbursement. These services include, but are not limited to, such basic educational programs as instruction in reading, science, mathematics, or GED.
- Vocational services are not reimbursable. Support services and activities directly related to assisting a client to cope with a mental illness in the work environment are reimbursable. Activities that focus on how to perform job functions are not reimbursable.
- Room and board, custodial care, and general supervision are not components of this service and are not reimbursable.
- Individuals, who reside in facilities whose license requires that staff provide all necessary services, are not eligible for this service.
- Providers shall be reimbursed only for training activities defined in the ISP and only where services meet the service definition, eligibility, and service provision criteria and guidelines as described in the regulations and this manual. Only direct face-toface contacts and services to the individual members are reimbursable.

- Staff travel time is excluded.
- MHSS may not be authorized or billed concurrently with Assertive Community Treatment, Multisystemic Therapy, Functional Family Therapy, Applied Behavior Analysis. MHSS may not be billed concurrently with Community Stabilization or Residential Crisis Stabilization Unit services. Short-term service authorization overlaps are allowable as approved by the FFS Contractor or MCO during transitions from one service to another for care coordination and continuity of care.
- Service may not be provided in groups where one staff person provides services to two or more individuals at the same time.

MHSS Provider Participation Requirements:

Provider Qualifications:

MHSS providers must be licensed by DBHDS as a provider of Mental Health Community Support services and be credentialed with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Services (FFS) contractor for individuals in FFS. MHSS providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.

Staff Requirements:

- MHSS services may only be rendered by LMHP, LMHP-S, LMHPR, LMHP-RP, QMHP-A, QMHP-C, QMHP-E or QPPMH under the supervision of a QMHP-A, a QMHP-C, a QMHP-E, or an LMHP, LMHP-S, LMHP-R, or LMHP-RP.
- Assessments must be conducted by a LMHP, LMHP-S, LMHP-R or LMHP-RP.

Documentation and Utilization Review:

Refer to Chapters IV and VI of this manual for documentation and utilization review requirements that apply to all providers of Mental Health Services.

MHSS Documentation Requirements – validating prior psychiatric and medication history

- Documentation of prior psychiatric services history shall be maintained in the individual's MHSS medical record. This requirement can be met by either:
  - A copy of a discharge summary from a prior provider that clearly indicates: (i) the type of treatment provided; (ii) the dates of the treatment previously provided; and (iii) the name of treatment provider; OR
  - Documentation of a telephone contact with a prior provider that includes the following minimum elements: (i) name and title of the caller; (ii) name and title of the professional who was called; (iii) name of the organization that the professional works for; (iv) date and time of the call; (v) specific placement provided; (vi) type of treatment previously provided; (vii) name of the treatment provider; and (viii) dates of previous treatment.

- The provider shall document evidence of psychiatric medication history. This requirement can be met by one of the following:
    - Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, including psychiatric medication history, (ii) the dates of the treatment previously provided, and (iii) the name of treatment; OR
    - Photocopies of prescription information from a prescription bottle; OR
    - Prescription list from a pharmacy or other provider that contains the following: (i) the name of the prescribing physician; (ii) the name of the medication with dosage and frequency; (iii) the date of the prescription; OR
    - Documentation of a contact with the pharmacy or other provider that includes the following minimum elements: (i) name and title of caller, (ii) name and title of professional who was called, (iii) name of organization that the professional works for, (iv) date and time of call, (v) specific prescription confirmed, (vi) name of prescribing physician, (vii) name of medication, and (viii) date of prescription
- Providers may use their own records to validate prior psychiatric and medication history, however they must clearly document in a MHSS progress note where in the electronic record substantiating information (ex: doctors' order for the meds, written report from a prescriber or hospital within the 12 months prior to the assessment date) can be found. When a provider uses their own records to validate prior psychiatric and medication history, the documentation referenced must meet the documentation requirements for prior psychiatric and psychiatric medication history outlined above.
- Family member statements shall not suffice to meet documentation requirements for prior psychiatric and psychiatric medication history outlined above.

MHSS Billing Requirements:

The provider shall clearly document details of the services provided during the entire amount of time billed. Service units are based on medical necessity.

- One unit = 1 to 2.99 hours per day
- Two units = 3 or more hours per day

Providers must follow the requirements for the provision of telemedicine described in the "Telehealth Services Supplement" including the use of the GT modifier for units billed for services provided through telemedicine. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.